WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case. Prescribers and pharmacy providers are required to retain a completed copy of the form.

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs form, HCF 11094. Pharmacy providers are required to use the PA/PDL for Cytokine and CAM Antagonist Drugs form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or when submitting a paper PA request.

Providers may submit PA/PDL requests in one of the following ways:

1) For STAT-PA requests, pharmacy providers should call (800) 947-1197 or (608) 221-2096.

2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), HCF 11018, and the appropriate PA/PDL form by fax to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    Wisconsin Medicaid
    Prior Authorization
    Ste 88
    6406 Bridge Rd
    Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
Enter the drug name.

Element 5 — Strength
Enter the strength of the drug listed in Element 4.

Element 6 — Date Prescription Written
Enter the date the prescription was written.

Element 7 — Directions for Use
Enter the directions for use of the drug.

Element 8 — Diagnosis — Primary Code and / or Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 9 — Name — Prescriber
Enter the name of the prescriber.

Element 10 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

These default codes must *not* be used for prescriptions for controlled substances.

Element 11 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code.

Element 12 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

Element 13 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 14 — Date Signed
Enter the month, day, and year the PA/PDL for Cytokine and CAM Antagonist Drugs form was signed (in MM/DD/YYYY format).

SECTION III — CLINICAL INFORMATION FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS

Include diagnostic and clinical information explaining the need for the drug requested. In Elements 15 through 17, check "yes" to all that apply.

Element 15
Prescribers are required to complete this element only if PA for a non-preferred drug is being requested. Currently, Amevive is the only non-preferred drug in this class. Indicate if the recipient has tried and failed or had an adverse reaction to a preferred cytokine or CAM antagonist drug. If the recipient has tried and failed or had an adverse reaction to a preferred cytokine or CAM antagonist drug, indicate the failed preferred drug name or the adverse reaction experienced by the recipient in the space provided.

Element 16 — Psoriasis
Complete these questions if requesting PA for treatment of psoriasis.

A. Indicate if the recipient has a diagnosis of moderate to severe plaque psoriasis (greater than or equal to 10 percent of body surface area) *and* significant functional disability. The recipient must have a diagnosis of moderate to severe plaque psoriasis with significant functional disability *or* a diagnosis of debilitating palmar/plantar psoriasis to begin treatment with a cytokine or CAM antagonist drug.

B. Indicate if the recipient has a diagnosis of debilitating palmar/plantar psoriasis. The recipient must have a diagnosis of moderate to severe plaque psoriasis with significant functional disability *or* a diagnosis of debilitating palmar/plantar psoriasis to begin treatment with a cytokine or CAM antagonist drug.

C. Indicate if the prescription was written by a dermatologist. The prescription must be written by a dermatologist for the recipient to begin treatment.

D. Indicate if the recipient has tried and failed or had an adverse reaction to methotrexate at a minimum dose of 15 mg per week, or if the recipient has tried and failed or had an adverse reaction to Soriatane. If one drug is contraindicated, the other drug must be tried before the recipient can begin treatment.

Element 17 — Rheumatoid Arthritis
Complete these questions if requesting PA for treatment of rheumatoid arthritis. For PA approval, providers must check "yes" for A or B and "yes" for C or D.

A. Indicate if the recipient has a diagnosis of moderate to severe rheumatoid arthritis.

B. Indicate if the recipient has a diagnosis of polyarticular juvenile rheumatoid arthritis, ankylosing spondylitis, or psoriatic arthritis. If the provider responds "yes" to any of these, indicate the diagnosis in the space provided on the form.

C. Indicate if the recipient has tried and failed or had an adverse reaction to one of the following: Arava, Cuprimine, hydroxychloroquine, cyclosporine, gold, azathioprine, or sulfasalazine.

D. Indicate if the recipient has tried and failed or had an adverse reaction to a methotrexate dose greater than or equal to 20 mg per week as a single agent or in combination with an agent listed in 17C. Recipients must try and fail or experience an adverse reaction to methotrexate **or** one of the drugs listed in Element 17C.

SECTION IV — PHARMACY PROVIDERS USING STAT-PA

Element 18 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 19 — Days' Supply Requested
Enter the requested days' supply. Days' supply requested equals the total number of days requested on the PA. For example, for a one-year PA, providers should enter "365."

Element 20 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 21 — Date of Service
Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 22 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be dispensed.

Code	Description
00	Not specified
01	Home
04	Long Term/Extended care
07	Skilled Care Facility
10	Outpatient

Element 23 — Assigned Prior Authorization Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 24 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 25 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 26 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 27
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.